

University of Louisville

Occupational Health Questionnaire for Individuals Working with Animals and Animal Tissues

Instructions:

Section I should be completed by employee and supervisor to identify job-related risks.

Section II contains personal medical history and should be completed by the employee only.

Completion of this questionnaire is required to enroll in the Occupational Health and Safety Program (OHSP). Enrollment in the OHSP is mandatory for all personnel working with animals, animal tissue, or in animal use areas.

For questions, please contact Occupational Health Nurse, Stacey Nalley, at 502-852-9893 or occmed@louisville.edu.

Personal Information		
Name (Last, First):		Today's Date:
Employee ID:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Cell Phone:	Email:	
Job Title:		
Supervisor:	Supervisor Phone:	

SECTION I: JOB-RELATED RISK ASSESSMENT

Occupational Duties and Laboratory Exposure	
Check the boxes below that apply to your job duties:	
<input type="checkbox"/> Animal cage wash facility	
<input type="checkbox"/> Animal Husbandry	
<input type="checkbox"/> Human cells, cell lines, blood or tissue	
<input type="checkbox"/> Unfixed animal tissue	
<input type="checkbox"/> Animal cell culture	
<input type="checkbox"/> Non-human primate tissue	
<input type="checkbox"/> Animals exposed to various infectious agents, chemical hazards, radiation, recombinant DNA or viral vectors	
<input type="checkbox"/> Formaldehyde	
<input type="checkbox"/> Anesthetic gases	Please list: _____
<input type="checkbox"/> Teratogens/carcinogens	Please list: _____
<input type="checkbox"/> Lasers	
<input type="checkbox"/> Anti-neoplastic drugs	Please list: _____
<input type="checkbox"/> Toxins/venoms	Please list: _____
<input type="checkbox"/> Other:	_____
Briefly describe job duties:	

Select the following personal protective equipment (PPE) used in your lab/work area.	
<input type="checkbox"/> Respiratory Protection: If yes, specify type: <input type="checkbox"/> PAPR <input type="checkbox"/> N95 <input type="checkbox"/> Other: _____	
If required to wear an N95, have you received fit testing? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last fit test if applicable: _____	
<input type="checkbox"/> Hearing Protection: If yes, list date of last hearing test: _____	

Occupational Laboratory Animal History

Do you/will you work with live animals in the workplace?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you/will you work with animal cadavers and/or animal tissues?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will animals be present in your work area?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have animals at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list species:	
Have you worked with laboratory animals in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list species:	
How long did you previously work with laboratory animals?				<input type="checkbox"/> N/A

Describe the type and extent of animal contact that you currently have in the workplace:

Species	Hours/Month	Species	Hours/Month	Species	Hours/Month
Rodents (mice/rats/hamsters/gerbils)		Guinea pigs		Pigs	
Fish/frogs (other aquatics)		Rabbits		Ruminants (sheep, goats, cattle)	
Wildlife (field studies)		Other:			

SECTION II: PERSONAL MEDICAL HISTORY

Participation in the Individual Risk Assessment:

- I wish to participate in the individual risk assessment. I understand that, upon my consent, select answers may be shared with the Department of Environmental Health and Safety (DEHS) for the purpose of identifying and controlling potential exposures. Otherwise, this information will be kept strictly confidential by Occupational Medicine.
- I have been advised that it is recommended that I participate in the individual risk assessment, but I have voluntarily decided **NOT** to participate.

Employee Signature: _____ Date: _____

Medical History

Do you have any significant medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been told by a provider that you are immunocompromised?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered "Yes" to either question, please specify:		
Are you currently pregnant or do you plan on becoming pregnant in the next 3 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergy History

Do you have any allergies to animals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any allergies to medications, chemicals, food, latex or environment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently under a provider's care for allergies or asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered "Yes" to any question, please specify:		

**Do you experience any of the following symptoms while working with animals in the workplace or at home?
(check all that apply)**

<input type="checkbox"/> Watery, burning, or itchy eyes	<input type="checkbox"/> Coughing	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Runny nose or sneezing	<input type="checkbox"/> Skin rash or hives
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> None

Immunization History

Disease	Vaccinated	Immune (positive titer)	Date(s) if Known
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	N/A	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Vaccine: Titer:

I hereby attest that the information in SECTION I was filled out in conjunction with my supervisor and that the information contained in this survey is true, accurate and complete to the best of my knowledge.

Employee Signature: _____

Date: _____

Clinic Use Only

- Cleared to work with no restrictions or additional accommodations
- Needs the following medical evaluation/intervention before receiving clearance:

- Cleared to work with no restrictions, but recommend the following:

- Reproductive Health consultation with Occupational Medicine
- Fit Testing
- Respirator use in the workplace
- Tetanus vaccine
- Hepatitis B vaccination series
- HBsAb titer
- Other:

Healthcare Provider Signature: _____

Date: _____